Motor Vehicle Accident Information

Patient Information

Name: _____ Date of Birth: _____

Social Security #: _____ Home Phone: _____

Address: _____

Auto Insurance Information:

Insurance Carrier: _____ Claim Number: _____

Address: _____

Insurance Phone: _____ Adjuster: _____

Note: You must bill your own personal auto insurance, not the insurance of the other party involved in the accident. Providing the wrong insurance will hold up your claim and could result in your being personally responsible for the bill.

Primary Health Insurance Information

Insurance Carrier: _____ Member #: _____

Address: _____ Group #: _____

Phone #: _____ Subscriber: _____

Accident Details:

Date of Accident: _____ Time: _____ am/pm Place: _____

Description of how the accident occurred: _____

_____

_____

Did you go to the ER? Yes/No When? _____

Which ER? _____ Were x-rays taken? Yes/No

Have you lost time from work? Yes/No

Attorney Information:

Attorney Name: _____ Phone Number: _____

Address: _____

Authorization:

I clearly understand and agree that I will pay for all services rendered to me regarding the auto accident detailed above if my auto insurance does not pay.

Patient Signature: _____ Date: _____

ACCIDENT QUESTIONNAIRE- Please answer all questions

Name: _____ [ ]male [ ]female

Address: _____
street city state zip

Social Security # ___-__-____ Your age_____ Date of Birth __/__/__

Phone home _____ work _____ cell _____

Family doctor _____
name address phone

Do you have a lawyer? If so, who? _____

Date of accident __/__/__ Were you injured while at work? [ ]yes [ ]no

If motor vehicle accident-

Were you the [ ]driver [ ]passenger [ ]pedestrian

In a [ ]car [ ]truck [ ]van [ ]taxi [ ]bus [ ] other_____

Who else was in your vehicle? _____

Was your vehicle hit [ ]from behind [ ]in the front [ ]on driver side

[ ]on passenger side [ ]other_____

What kind of vehicle was the one that your vehicle was hit by?_____

Did any parts of your body strike any parts of the inside of the vehicle?- if yes,

please explain_____

Please describe the accident_____

_____

_____

_____

How did you feel **immediately** after the accident? _____

Did anything hurt you **later that day**? _____

What hurts you **now**? _____

Did you go to the [ ]hospital [ ]doctor office? Where? _____

When? [ ]immediately after accident [ ]later that day [ ]other_____

How did you get there? [ ]ambulance [ ]you drove [ ]someone else drove

What did they do? [ ]examination [ ]x-rays [ ]other_____

Name of drugs or prescriptions given _____

What did they tell you was wrong with you? _____

Have you ever injured any of these areas before this accident? If yes, please explain _____

_____

Do you now or have you ever had [ ]diabetes [ ]high blood pressure [ ]heart attack
[ ]stroke [ ]HIV/AIDS [ ]cancer [ ]pacemaker
[ ]other significant disease_____

List any operations you have ever had _____

_____

List all medications you are currently taking _____

_____

Are you pregnant? [ ]yes- how many months_____ [ ]no [ ]maybe
Date of last menstrual period _____

Are you currently employed? If yes, where _____

What do you do at your job? _____

Have you have missed any work because of this accident? If yes, when _____

Is there any other information you would like to tell the doctor? _____

_____

_____

_____

Mian Family Medicine, LLC

Authorization to Release Health Information

Patient Name: _____ Date of Birth _____/_____/_____

Phone number: _____ Social Security #: ____-____-_____

Please send Records From:

Mian Family Medicine
9114 Philadelphia Rd, Suite #214
Baltimore, MD 21237
Ph: 443-231-5711
Fax: 443-231-5790

Send To:

_____
_____
_____
_____
_____

I authorize this information to be faxed and/or mailed.
This information is being disclosed for the purpose of Continuing Health Care.
Records are being requested for healthcare covering the period (s):

All (circle if choice) or From: _____ To: _____

Complete Health Record to be disposed or (Circle appropriate choices)

History and Physical Exam	Progress Notes
Discharge Summary	X-rays/Ultrasounds
Laboratory Tests	Consultations
	Billing Statements

I understand that specific information to be released may or may not include AIDS or HIV, Alcohol and/or Drug Abuse and Mental Health.
I understand that if I request copies of records for myself and or a member of my family, a review of this information with my physician or other healthcare provider is encouraged. I understand that if the physician does not feel it is in my best interest, I may designate another healthcare provider to receive these records. I accept responsibility for these copies and information contained herein.

Unless otherwise indicated, this authorization with expire ninety (90) days from the date of signature. The physician and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that the authorization may be revoked in writing at anytime, except to the extent that action has been taken in reliance on this authorization for the purposes stated above.
I understand that there may be a fee for preparing and furnishing this information.

_____ ____/____/_____
Signature of Patient/legal representative Date
Relationship to patient

PLEASE LIMIT FAXED PAGES TO NO MORE THAN 25 SHEETS. Any records which are more than 25 pages maybe mailed to the above address.